

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

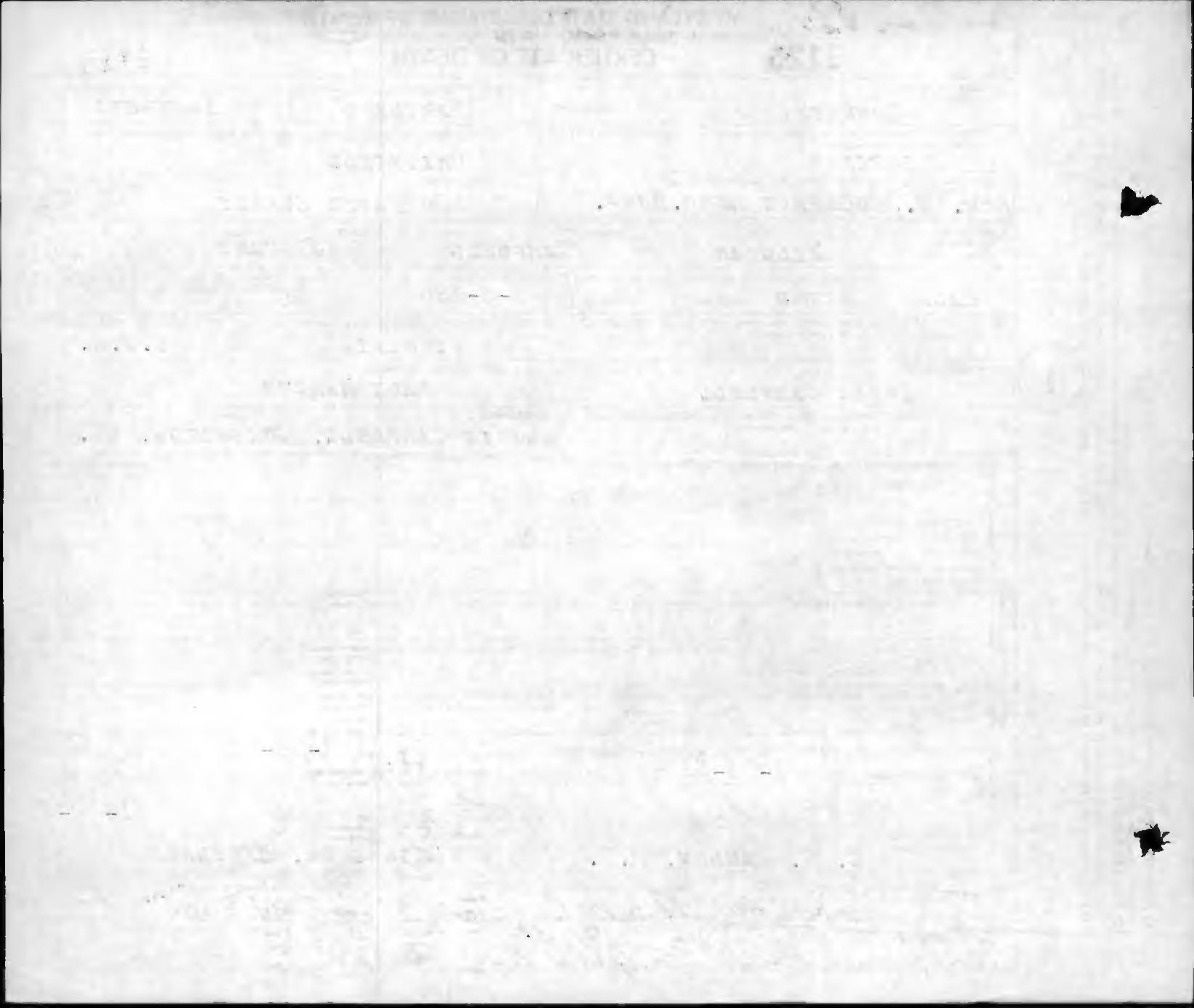
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1125

CERTIFICATE OF DEATH

(1113)

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. McCREADY MEMO.HOSP.		e. STREET ADDRESS 204 PAPER STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM	First WILLIAM	Middle CAMPBELL	Last CAMPBELL
4. DATE OF DEATH JANUARY 24 1961	Month JANUARY	Day 24	Year 1961
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-1905
9. AGE (In years last birthday) 55 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10a. CAMPBELL	11. KIND OF BUSINESS OR INDUSTRY 10b. CAMPBELL	12. BIRTHPLACE (State or foreign country) VIRGINIA
13. FATHER'S NAME ISAAC CAMPBELL	14. MOTHER'S MAIDEN NAME MARY HARCUM	15. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	17. SOCIAL SECURITY NO. GLADYS CAMPBELL, CRISFIELD, MD.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary thrombosis			
DUE TO arteriosclerotic myocardial			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. failure			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH 5 mos.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-24-61 to 1-24-61 , 19, that (I) (we) last saw the deceased alive on 1-24-61 19, and that death occurred at 11:20 AM M. from the causes and on the date stated above.			
22a. SIGNATURE C. G. Rawley	22b. ATTENDING M.D. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. PHYSICIAN'S NAME (Type) C. G. Rawley, M.D.	22d. ADDRESS CRISFIELD, MARYLAND
23a. BURIAL, CREMATION, REMOVAL (Specify) Jan 28, 1961	23b. DATE THEREOF 1961	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Asbury Cemetery Crisfield Md.	23d. LOCATION (City, town, or county) (State) Md.
24. FUNERAL DIRECTOR'S SIGNATURE Hathaway E. Ward	25a. REC'D BY REGISTRAR 1155 4th St. Crisfield Md.	25b. REGISTRAR'S SIGNATURE DAN 30 '61	Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1126

CERTIFICATE OF DEATH

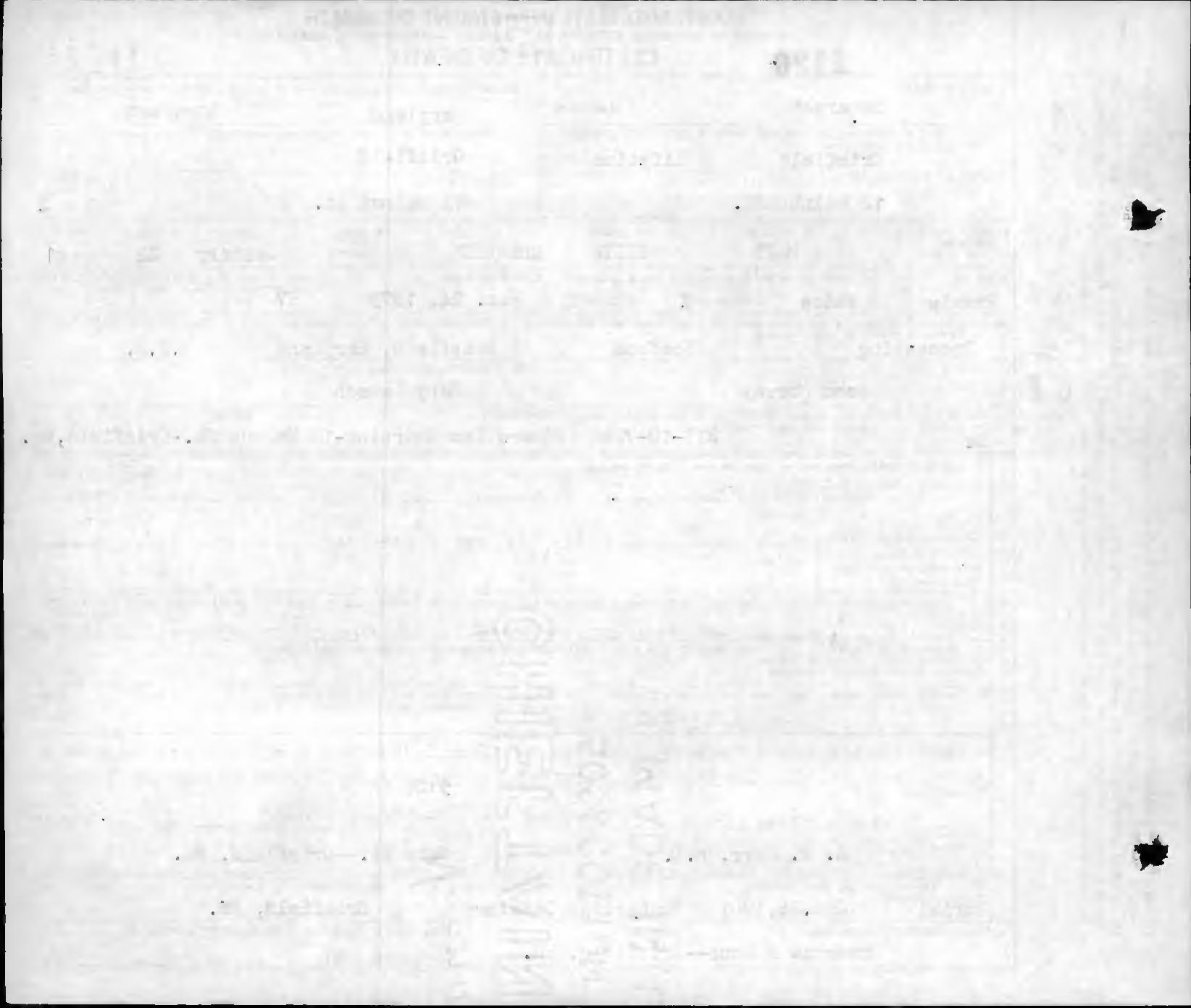
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1. PLACE OF DEATH a. COUNTY Somerset			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN lb Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12 Walnut St.			d. STREET ADDRESS 12 Walnut St.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARY		First Middle Last EDITH CHARNICK		4. DATE OF DEATH Month Day Year January 22 1961	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Jan. 24, 1873		9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Processing			10b. KIND OF BUSINESS OR INDUSTRY Seafood		
11. BIRTHPLACE (State or foreign country) Crisfield, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Horsey			14. MOTHER'S MAIDEN NAME Mary Lawson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 213-10-7269		
17. INFORMANT Edward Lee Charnick-12 Walnut St.-Crisfield, Md.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arteriosclerotic Heart Disease (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 30 min Known 7 1/2 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diseasing aneurysm at bifurcation of Aorta - 24 hrs before death					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/2 1954 to 1/24 1961 , that (I) (we) last saw the deceased alive on 1/23 1961 , and that death occurred at 5:00 PM from the causes and on the date stated above.					
22a. SIGNATURE A. N. Barr, M.D.			22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) A. N. Barr, M.D.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Jan. 26, 1961		
23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery			23d. LOCATION (City, town, or county) Crisfield, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons-Crisfield, Md.			25a. ADDRESS ADDRESS		
			25b. REC'D BY REGISTRAR DATE JAN 30 '61		
			25c. REGISTRAR'S SIGNATURE Curious & Timorous		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

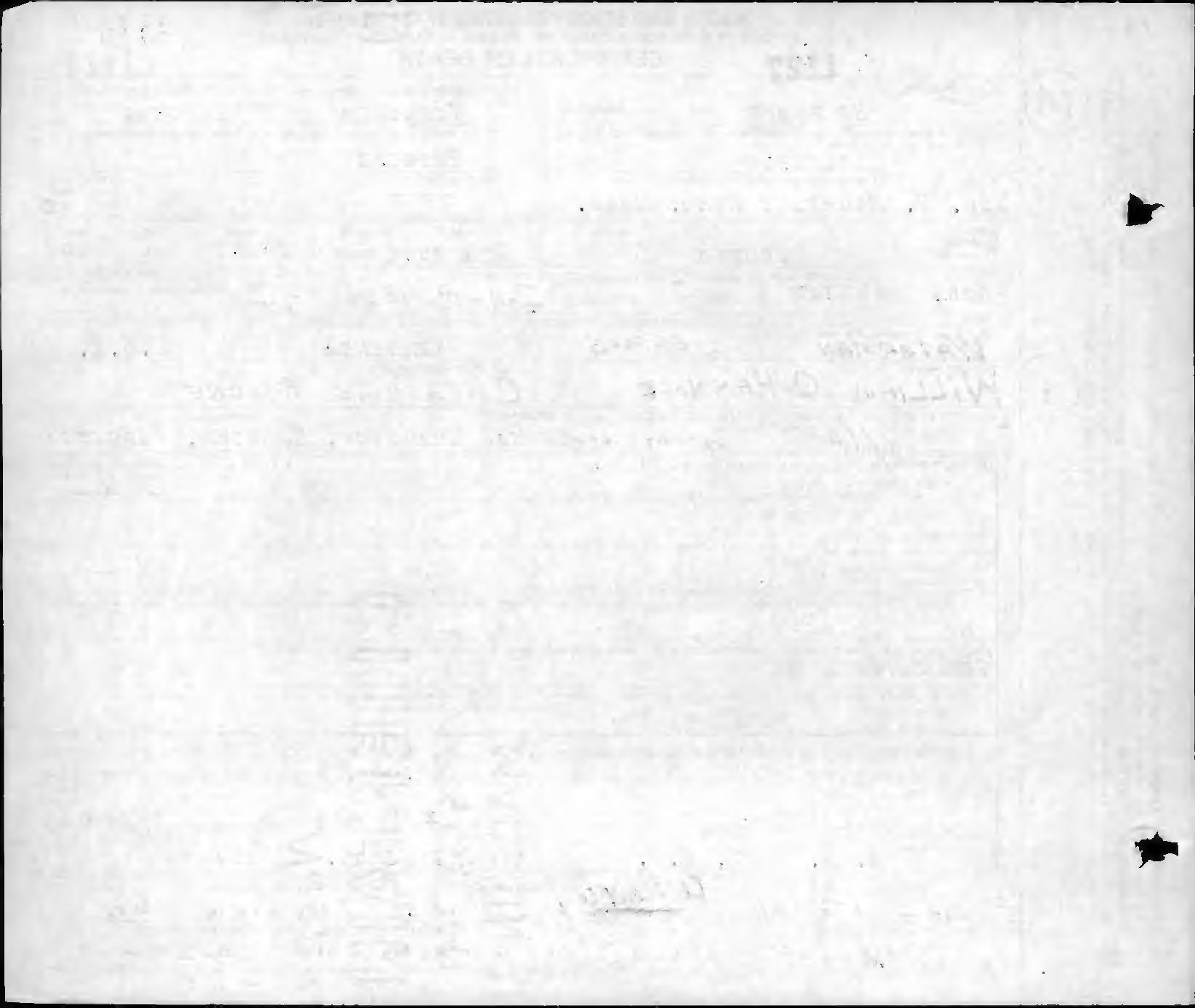
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1127

CERTIFICATE OF DEATH

1114

1. PLACE OF DEATH a. COUNTY SOMERSET		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA		b. COUNTY ACCOMAC				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b EDW. W. McCREADY MEMO. HOSP.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TANGIER		d. STREET ADDRESS 83X				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. McCREADY MEMO. HOSP.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First JOSEPH	Middle L	Last CHARNOCK	4. DATE OF DEATH JANUARY	Month 3	Day 1961			
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN-19-1886		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS. Days 4	Hours 00	Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN			10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILLIAM CHARNOCK		14. MOTHER'S MAIDEN NAME CATHERINE MOORE								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 223-24-2642		17. INFORMANT THOMAS CHARNOCK, TANGIER, VIRGINIA		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Type Measles INTERVAL BETWEEN DUE TO 24 hours										
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) Cerebral Vascula. Arterit. 19 days DUE TO } (c) Arteriosclerosis & Hypertension Unknown										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Miss Diabetes Mellitus, known forty years.										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) TANGIER		(County) UN		(State)
21. I certify that (I) (this hospital) attended the deceased from 12/15 , 19 60 , to 1/3 , 19 61 , that (I) (we) lost sow the deceased alive on 1/3 , 19 61 , and that death occurred at 3:25 PM from the causes and on the date stated above.										
22a. SIGNATURE A. N. Barr, M.D.		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/3/61				
22c. PHYSICIAN'S NAME (Type) A. N. BARR, M.D.		22d. ADDRESS CRISFIELD, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-6-61		23c. NAME OF CEMETERY OR CREMATORIAL CRISFIELD METHODIST		23d. LOCATION (City, town, or county) TANGIER UN				
24. FUNERAL DIRECTOR'S SIGNATURE L. J. Webster		ADDRESS Crisfield 7th		25a. REC'D BY REGISTRAR DATE JAN 12 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
112 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 61116

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Marion		c. LENGTH OF STAY IN lb lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Marion			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS /			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Laertes		First Cornelius	Middle Cottman	Last	4. DATE OF DEATH Month Jan. Day 12 Year 19 61		
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 10, 1960	9. AGE (In years and birthday) 6 mo exp.	10. IF UNDER 1 YEAR Months 6 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Westover, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Christopher Cottman		14. MOTHER'S MAIDEN NAME Corrine Smith					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Mrs. Corrine Cottman, Marion, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Pneumonia INTERVAL BETWEEN ONSET AND DEATH Unknown							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 493X		(b)					
		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>C. G. Rawley</i>		DATE SIGNED 1/13/61					
EXAMINER'S NAME (Type) C. G. Rawley, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 15, 1961		22c. NAME OF CEMETERY OR CREMATORIUM John Wesley Cemetery		22d. LOCATION (City, town, or county) Cottage Grove Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Funeral Home		ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR JAN 19 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

SUPERIOR QUALITY AND SERVICE ARE THE FOUNDATION OF OUR BUSINESS.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

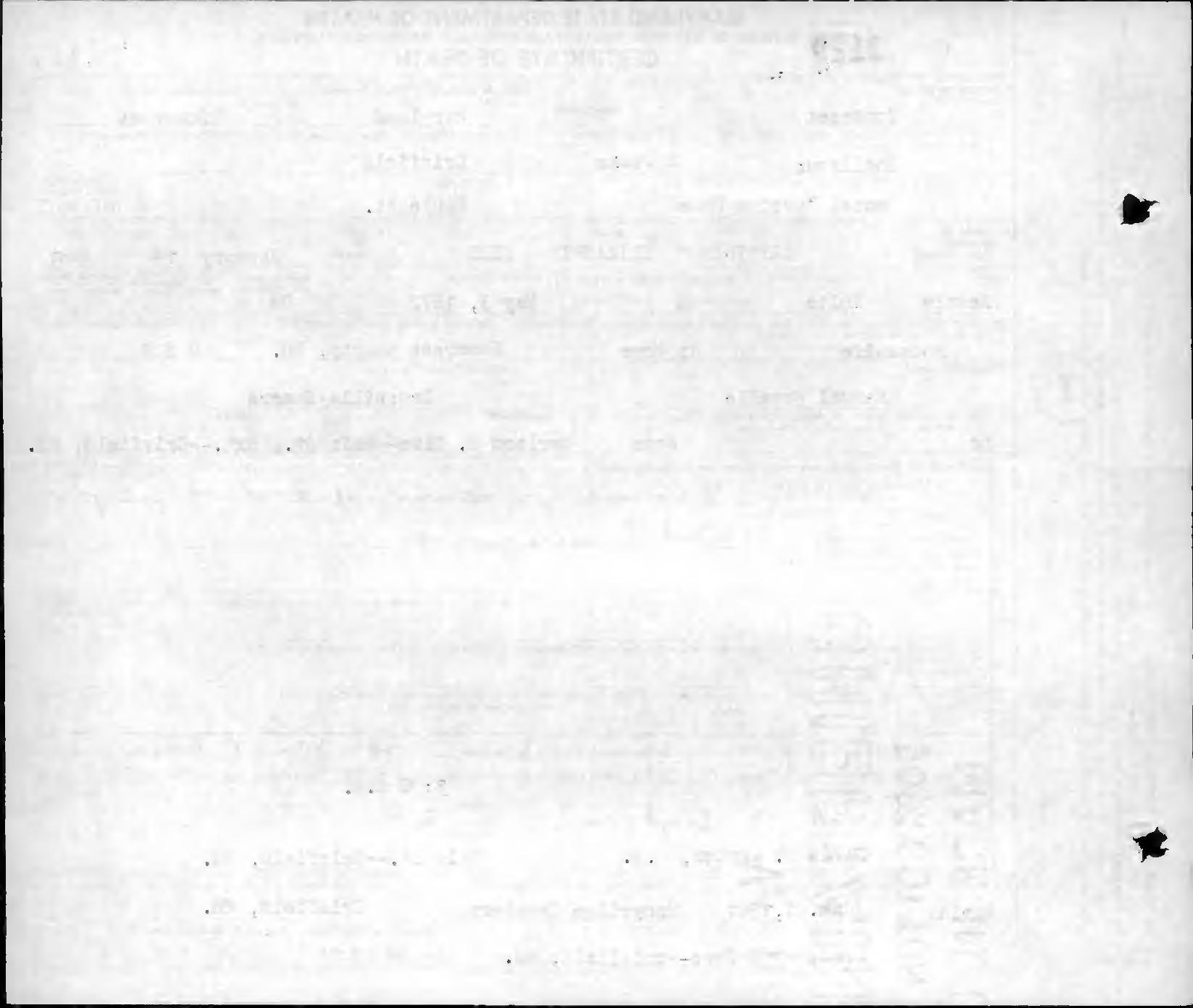
**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

1129

CERTIFICATE OF DEATH

(1117)

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shelltown		c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 Crisfield		d. STREET ADDRESS Maple St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Menzel Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ARINTHIA		First ELIZABETH	Middle DIZE	Last	4. DATE OF DEATH January 19	Month January	Day 19	Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 3, 1872	9. AGE (In years lost birthday) 88 yrs.	IF UNDER 1 YEAR Months 88	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Somerset County, Md.		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Samuel Revelle				14. MOTHER'S MAIDEN NAME Druscilla Somers		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Carlton E. Dize--Main St., Ext.--Crisfield, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Failure DUE TO 450.0									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Jan 19 1961		(County) Jane 19 1961	(State) Jane 19 1961
21. I certify that (I) (this hospital) attended the deceased from Jan 19 1961 to Jan 19 1961 that (I) (we) last saw the deceased alive on Jan 10 1961 , and that death occurred at 5:00 A.M. M. from the causes and on the date stated above.									
22a. SIGNATURE Sarah M. Peyton		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Jan 23 1961		
22c. PHYSICIAN'S NAME (Type) Sarah M. Peyton, M.D.		22d. ADDRESS Main St.--Crisfield, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 21, 1961		23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery		23d. LOCATION (City, town, or county) Crisfield, Md.			(State)
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 23 '61		25b. REGISTRAR'S SIGNATURE Carlton E. Kraus			

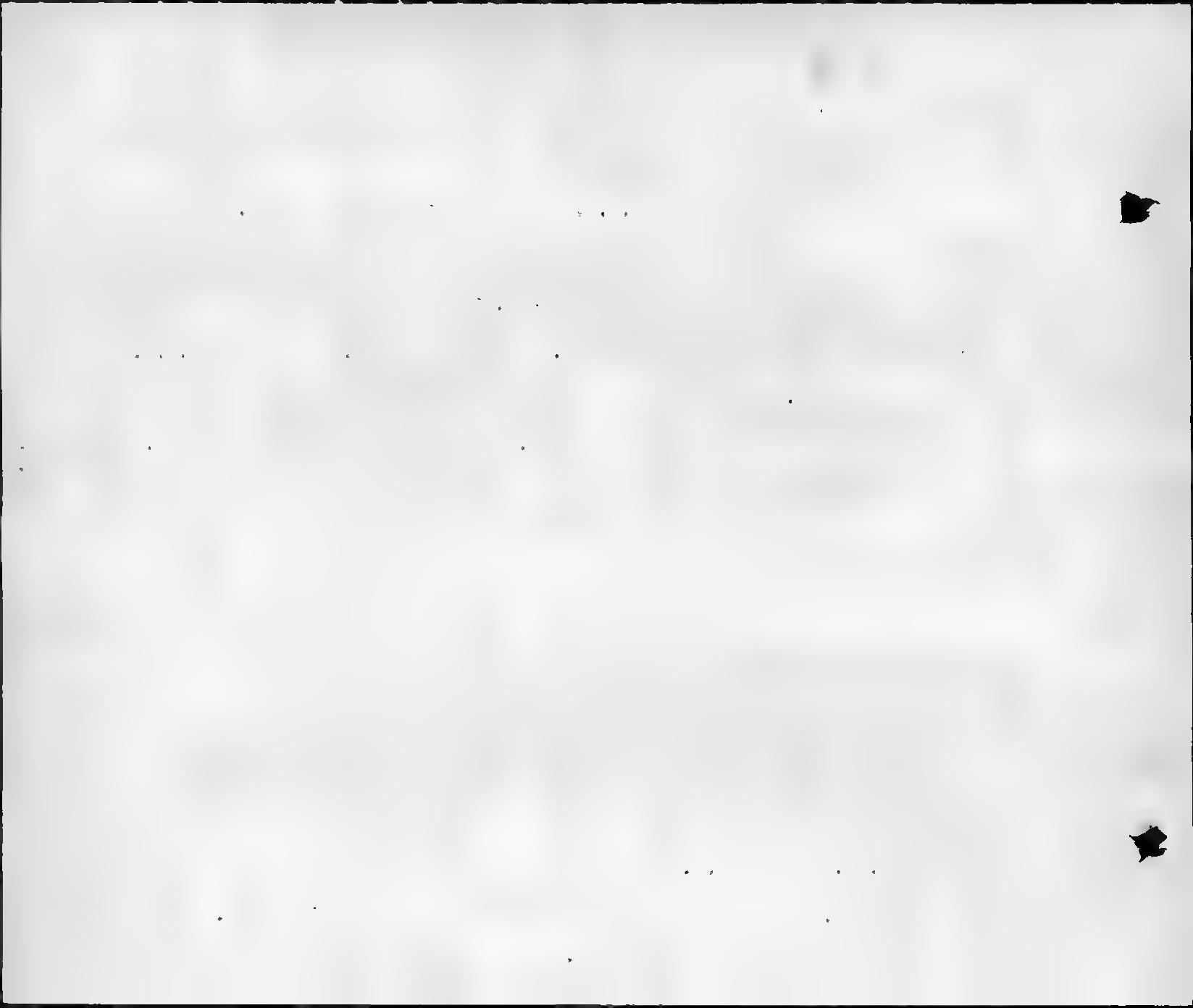


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VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1130 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												Reg. Dist. No. 1118	
1. PLACE OF DEATH a. COUNTY Somerset				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Somerset					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b lifetime				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Hospital (D.O.A.)				d. STREET ADDRESS 121 Richardson Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First HARRY	Middle ---	Last EVANS		4. DATE OF DEATH Month January	Day 12	Year 1961					
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 17, 1883		9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS. Days 0		12. IF UNDER 24 HRS. Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Coal & Wood Co.		11. BIRTHPLACE (State or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jesse D. Evans				14. MOTHER'S MAIDEN NAME Rachael Ward									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Name, no., or unknown] No		16. SOCIAL SECURITY NO. 220-32-9868A		17. INFORMANT Mrs. Dora Tawes--121 Richardson Ave.-Crisfield,		Address Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH instantaneous													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None													
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH,		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Crisfield, Md.		(County) 0		(State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>C. G. Rawley</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/13/61					
EXAMINER'S NAME (Type) C. G. Rawley, M.D.													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 14, 1961		22c. NAME OF CEMETERY OR CREMATORIUM Crisfield Cemetery		22d. LOCATION (City, town, or county) Crisfield, Md.		(State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 20 '61		24b. REGISTRAR'S SIGNATURE <i>C. G. Rawley</i>							

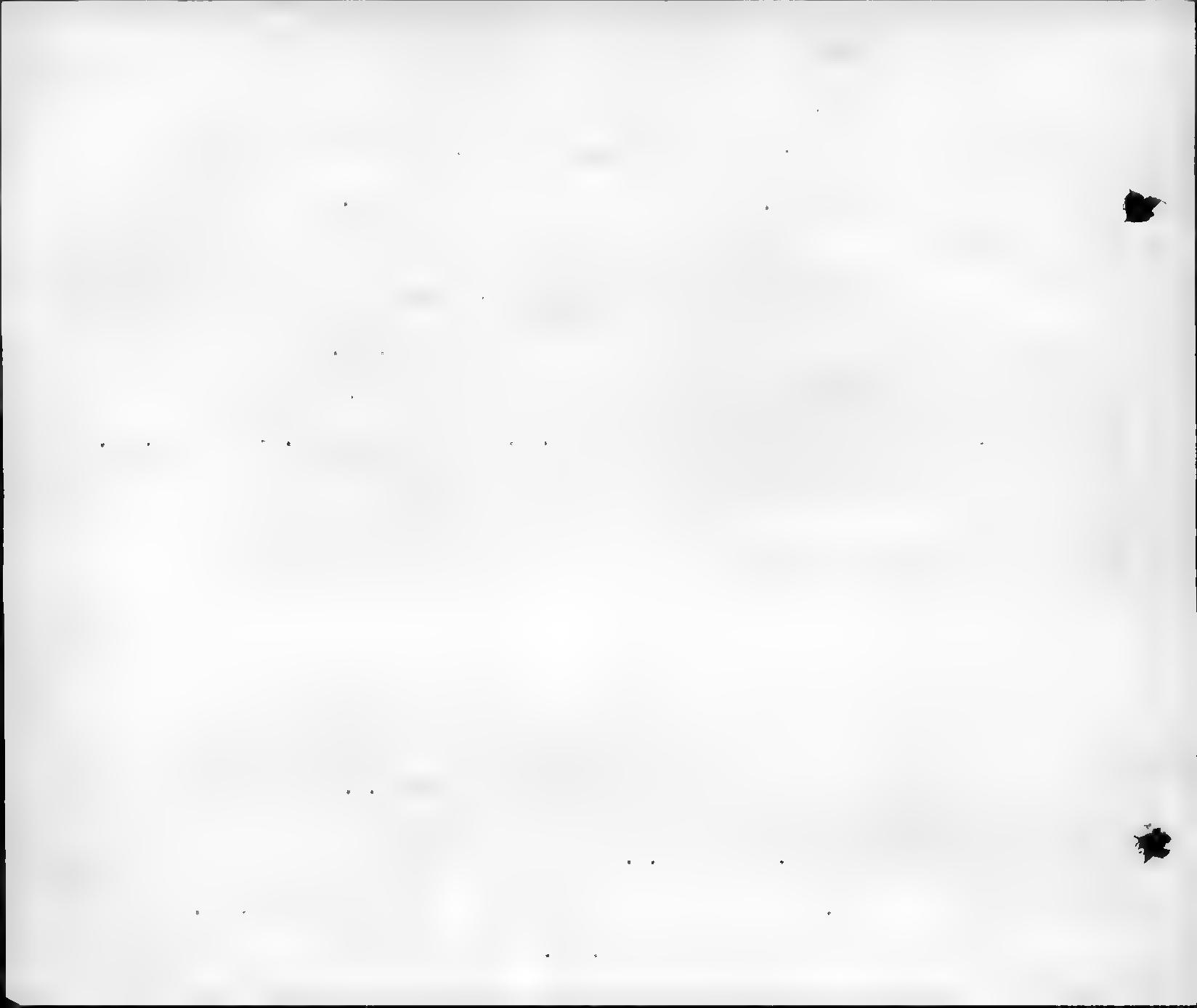


TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												6116							
1132				CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY Somerset				b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b Lifetime				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland				b. COUNTY Somerset			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 34 Main St.								c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				d. STREET ADDRESS 34 Main St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First OLEVIA		Middle M.		Last GIBSON		4. DATE OF DEATH January 19		Month 1961		Day Year							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) March 3, 1870		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. KIND OF BUSINESS OR INDUSTRY At Home		12. BIRTHPLACE (State or foreign country) Crisfield, Md.		13. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME William Batts				14. MOTHER'S MAIDEN NAME Burnetta Sterling															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT None		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 2 mo -				Address							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)																	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from Jan. 19, 1961 to Jan. 19, 1961 , that (I) (we) last saw the deceased alive on Jan. 19, 1961 and that death occurred at 4:00 P.M. M. from the causes and on the date stated above.												22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) Sarah M. Peyton, M.D.		22d. ADDRESS																	
23a. BURIAL, CREMATON REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 22, 1961		23c. NAME OF CEMETERY OR CREMATORIUM Crisfield Cemetery				23d. LOCATION (City, town, or county) Crisfield, Md.				(State)							
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		ADDRESS				25a. REC'D BY REGISTRAR DATE JAN 23 '61		25b. REGISTRAR'S SIGNATURE Livingston, L. Thomas											



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1133

CERTIFICATE OF DEATH

Reg. Dist. No. 61160

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHANCE</u>		c. LENGTH OF STAY IN 1b <u>LIFETIME</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HOME</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHANCE</u>	
3. NAME OF DECEASED (Type or print) <u>CALVIN T.</u>		First <u>CALVIN</u>	Middle <u>T.</u>
		Last <u>GLADDEN</u>	4. DATE OF DEATH <u>JAN 10</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 5 - 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SALESMAN</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>GEORGE GLADDEN</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH SHORES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>CARRIE GLADDEN - CHANCE MA</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Chronic Cystitis</u> DUE TO lying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Cystitis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>CHANCE</u>
20f. (City or town) <u>Princess Anne</u>		(County) <u>MD</u>	(State) <u>MD</u>
21. I certify that I attended the deceased from <u>APRIL 15, 1956</u> , to <u>JAN 10, 1961</u> , that I last saw the deceased alive on <u>JAN 10, 1961</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Princess Anne, MD</u> DATE SIGNED <u>1/11/61</u>			
ACTUAL SIGNATURE <u>Eisen G. D. Kaufman M.D.</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL JAN 12 1961</u>		22b. DATE THEREOF <u>JAN 12 1961</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>ROCK CREEK</u>
22d. LOCATION (City, town, or county) <u>CHANCE</u>		(State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. G. Webster</u>		ADDRESS <u>Dead Island, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>JAN 16 '61</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thrus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pgce 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1134

CERTIFICATE OF DEATH

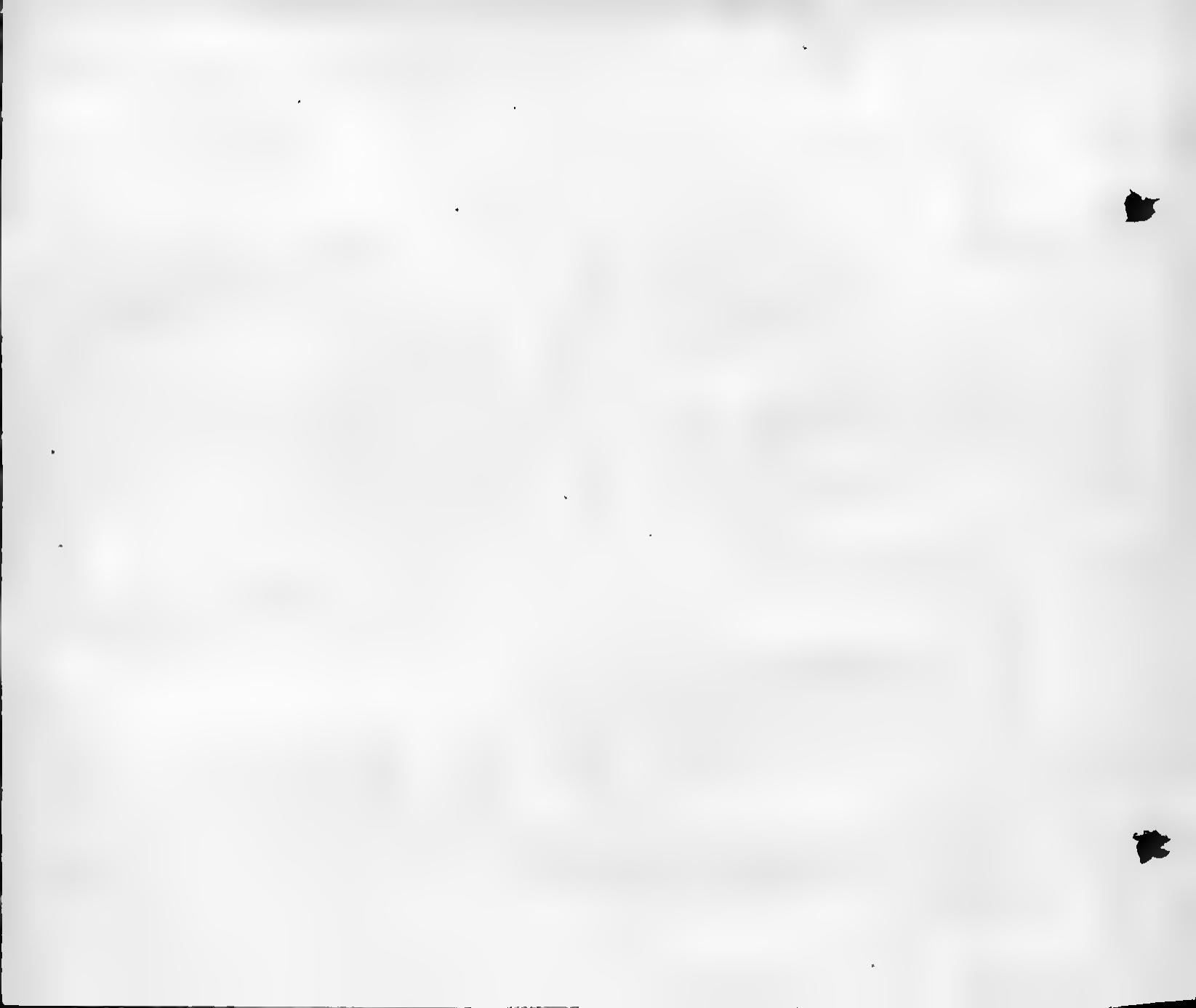
Reg. Dist. No. 6121

1. PLACE OF DEATH a. COUNTY Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN 1b Life time	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR (INSTITUTION)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne	
3. NAME OF DECEASED (Type or print) Nutter		First	Middle
		Last	
4. DATE OF DEATH Holl		Month	Day
		I	3
5. SEX Male		6. COLOR OR RACE Color	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH 12/25/1907	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) England
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert Holl		14. MOTHER'S MAIDEN NAME Sarah James	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Sallie Turnell, Princess Anne, Md.
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO Hyperension		INTERVAL BETWEEN ONSET AND DEATH 5 days 4 yrs	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from Dec 24, 1960, to Jan 3, 1961, that I last saw the deceased alive on Jan 2, 1961, and that death occurred at 7:10 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Baltimore, Maryland DATE SIGNED Jan 4/1961	
ACTUAL SIGNATURE B. FRANK GIGANTI M.D.			
PHYSICIAN'S NAME (Type) B. FRANK GIGANTI			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/2/61	22c. NAME OF CEMETERY OR CREMATORIAL St. Mark	22d. LOCATION (City, town, or county) Calverton, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE James J. Princess Anne		ADDRESS	
		24a. REC'D BY REGISTRAR DATE JAN 9 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS 14
1SM 9/55



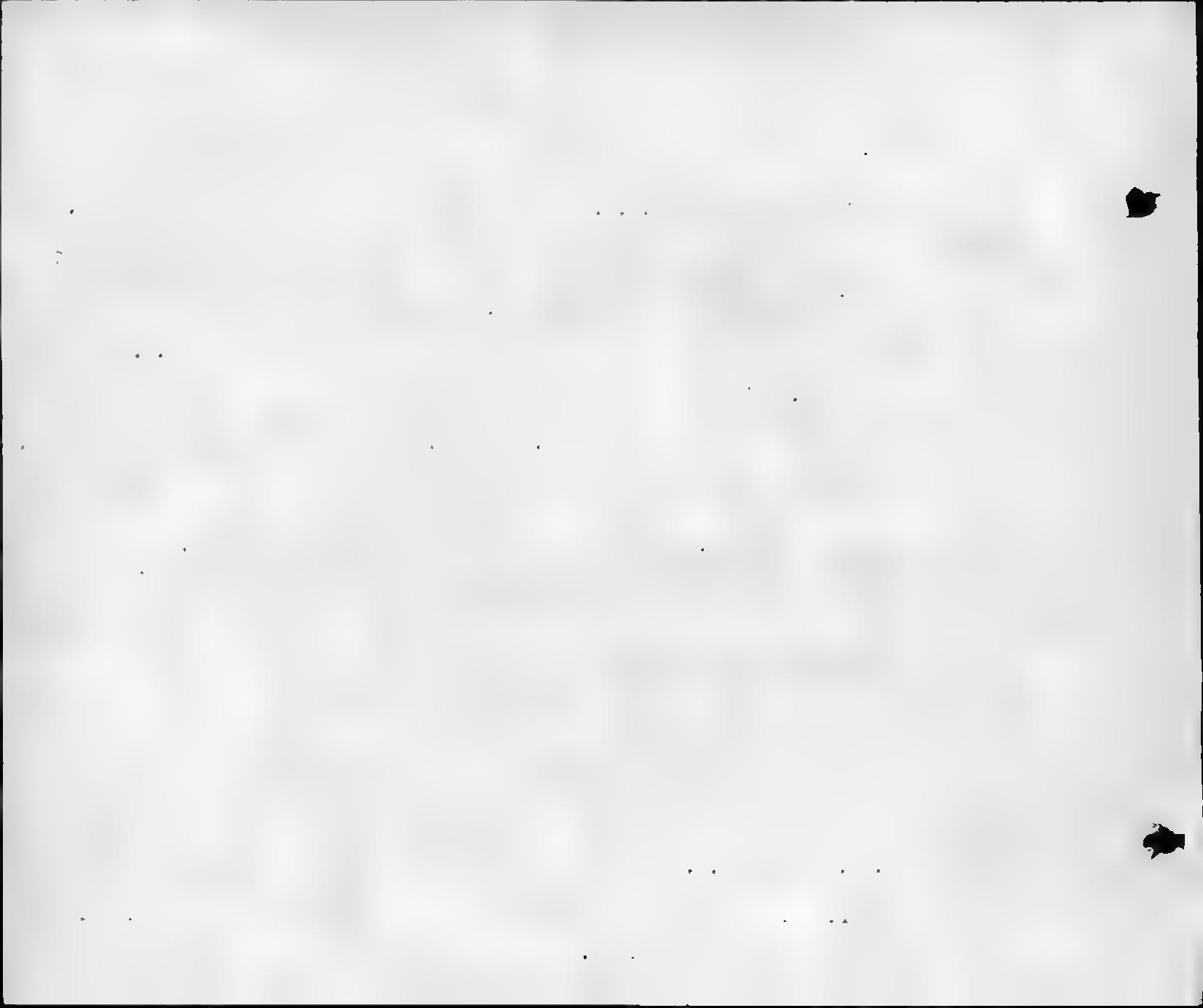
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
113 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **112**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Somerset			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield			c. LENGTH OF STAY IN 1b None		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Hospital (D.O.A.)			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tylerston		
3. NAME OF DECEASED (Type or print) WILLARD ORVILLE LAIRD			4. DATE OF DEATH Month January Day 11 Year 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1916	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Tangier Island, Virginia	
13. FATHER'S NAME Willard M. Laird			14. MOTHER'S MAIDEN NAME Daisy Pruitt		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Rosie T. Laird--Tylerston, Smith Island, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pat. hospitalized McCready Memorial Hosp.					
DUE TO July 1957 with diagnosis coronary occlusion. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>C. G. Rawley</i>			DATE SIGNED 1/12/61		
EXAMINER'S NAME (Type) C. G. Rawley, M.D.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 15, 1961	22c. NAME OF CEMETERY OR CREMATORIUM Tylerston Cemetery	22d. LOCATION (City, town, or county) Tylerston, Smith Island, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.			24a. REC'D BY REGISTRAR JAN 20 1961	24b. REGISTRAR'S SIGNATURE Arthur S. Traud	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rebuffed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



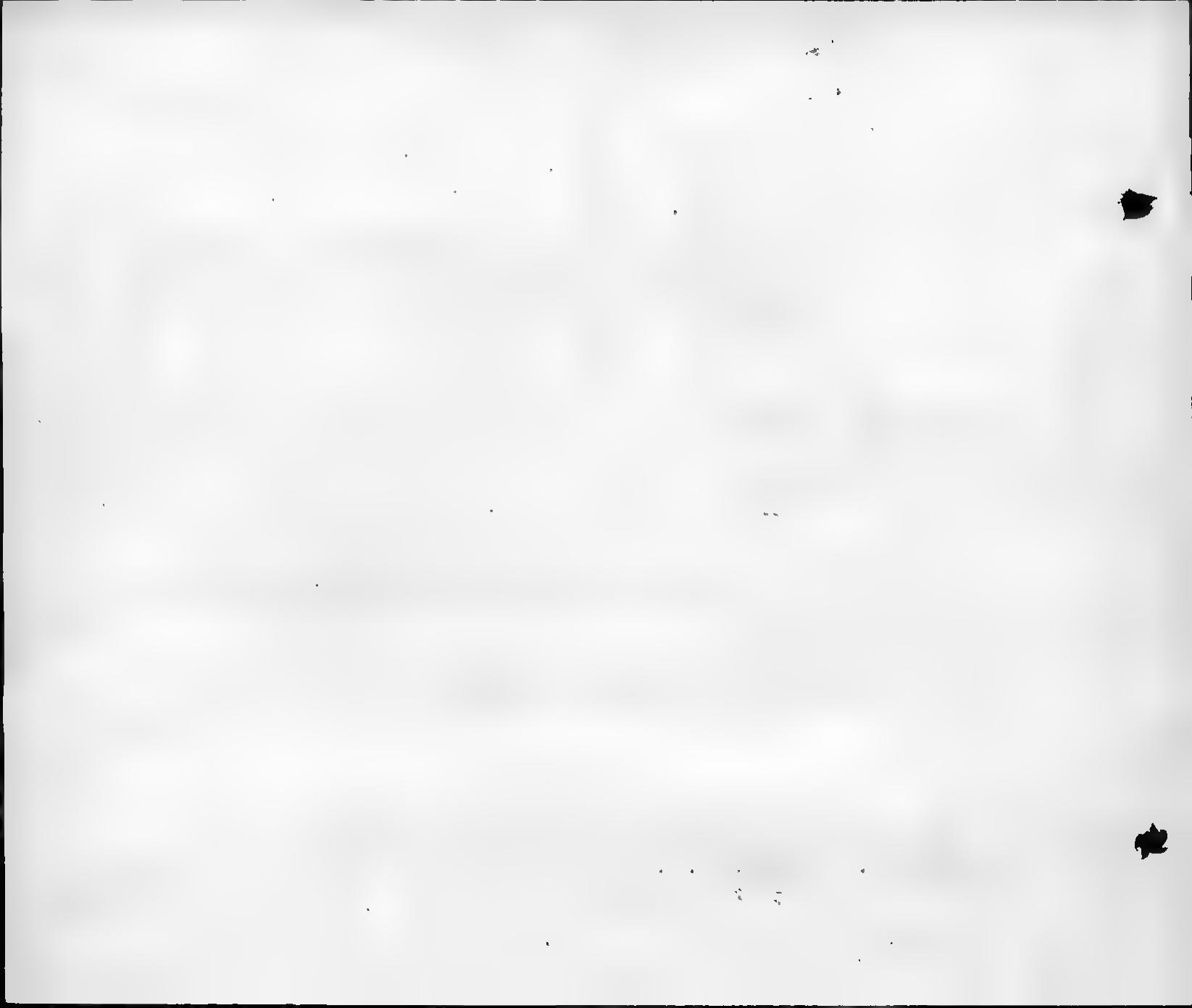
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1136

CERTIFICATE OF DEATH

Items 7, 9 Film 6278 1-10-61 set 61183

1. PLACE OF DEATH a. COUNTY		SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		CRISFIELD		a. STATE MARYLAND b. COUNTY SOMERSET	
c. LENGTH OF STAY IN 1b		62 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		EDW. W. MCCREADY MEMO. HOSP.		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7 MAIN STREET			
3. NAME OF DECEASED (Type or print)		First JOHN	Middle E	Last MILES	4. DATE OF DEATH JANUARY 2 1961
5. SEX MALE		6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH APPROX.	9. AGE (In years lost birthday) 62 yrs
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ROBERT MILES		14. MOTHER'S MAIDEN NAME SARAH HOLLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
				ANNIE MILES, 7 MAIN St., CRISFIELD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>liver cancer</i>					
572-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>terminal liver failure pyo hydrocephalus 3 yrs</i> (c) <i>Restal diverticulitis vesico-ureteral fistula 5 yrs</i>					
INTERVAL BETWEEN ONSET AND DEATH 3 days					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
Certifying here					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour o m p m		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that (I) (this hospital) attended the deceased from 1/2/61 to 1/2/61, that (I) (we) last saw the deceased alive on 1/2/61, and that death occurred at 9 P.M. from the causes and on the date stated above					
22a. SIGNATURE		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
Sarah M. Peyton, M.D.					
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
SARAH M. PEYTON, M.D.		CRISFIELD, MARYLAND			
23a. BURIAL, CREMAT. ON, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIALy	
23a. BURIAL, CREMAT. ON, REMOVAL (Specify)		23b. DATE THEREOF		23c. LOCATION (City, town, or county) (State)	
Jan. 8, 1961		Asbury Cemetery		Crisfield (Towson) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		REC'D BY REGISTRAR	
H. L. Ward		112 S. 4th St.		DATE JAN 5 '61	
Crisfield Md					



TO HOSPITAL ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of the death: Page 4 may be retained by the hospital or attending physician.

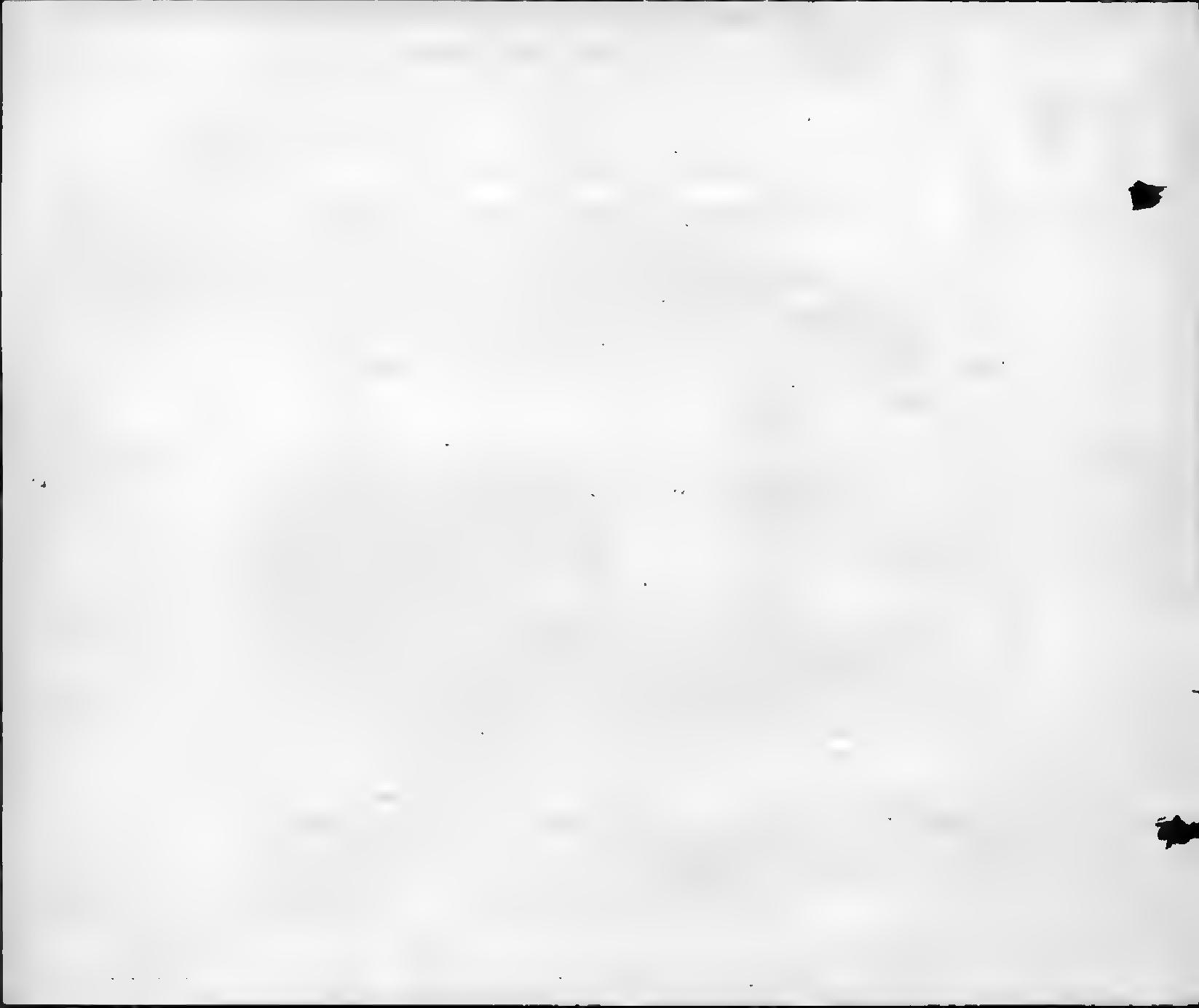
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 61164

1. PLACE OF DEATH o COUNTY <i>Towson</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE <i>Maryland</i> b COUNTY <i>Baltimore</i>					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore City</i>		c LENGTH OF STAY IN 1b <i>Several days</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Woodall's Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore City (Resid)</i>					
f. STREET ADDRESS <i>1220 E. 36th St.</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Mary Elizabeth Bellott</i>		First <i>Mary</i>	Middle <i>Elizabeth</i>				
		Last <i>Bellott</i>	4. DATE OF DEATH <i>1/13/61</i>				
5. SEX <i>F</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 1, 1884</i>				
9. AGE (In years last birthday) <i>76 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Employer</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>				
13. FATHER'S NAME <i>William Bellott</i>	14. MOTHER'S MAIDEN NAME <i>McKee</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>0</i>				
17. INFORMANT <i>Horace Cottman</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Hemiplegia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). <i>Arteriosclerosis</i> DUE TO (b) <i>Cerebral Hemorrhage</i> DUE TO (c) <i>Hypertension - Senility</i> INTERVAL BETWEEN ONSET AND DEATH <i>Two hours</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>Bronchitis</i>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Arteriosclerosis</i>	20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Dec 3 1960</i> to <i>Jan 13 1961</i> , that I last saw the deceased alive on <i>Jan 13 1961</i> , and that death occurred at <i>Baltimore</i> at <i>1 P.M.</i> from the causes and on the date stated above.	ACTUAL SIGNATURE <i>M.E. Sartorius</i>	ADDRESS <i>1220 E. 36th St., Baltimore City Md.</i>	DATE SIGNED <i>1/13/61</i>				
22a. BURIAL, CREMATON, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-15-61</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Tindale Chapel</i>	22d. LOCATION (City, town, or county) <i>Potomac Md.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Wharton - New Church, etc.</i>	ADDRESS	24a. REC'D BY REGISTRAR <i>SAN 18 '61</i>	24b. REGISTRAR'S SIGNATURE <i>O. L. S. Kline</i>				



1
FOR STATE
HEALTH DEPT.

Please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-2. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1138

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(112)

1. PLACE OF DEATH

a. COUNTY

Somerset

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

Princess Anne

c. LENGTH OF STAY IN lb

MARYLAND

Lifetime

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

M

3. NAME OF
DECEASED
(Type or print)

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY

13. FATHER'S NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) If yes give war or dates of service

No

16. SOCIAL SECURITY NO

17. INFORMANT

None

Corine Jones

Oriole, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420.1 DUE TO

Conditions, if any, which

gave rise to immediate cause

(a), stating the underlying

cause last.

(b)

DUE TO

(c)

Acute Coronary Heart Disease

INTERVAL BETWEEN
ONSET AND DEATH

Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED While
at work Not While
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy

Inspection

Inquiry

and in my opinion

death resulted from.

Natural causes

Accident

Suicide

Homicide

Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

Burial Jan. 15, 1961

22c. NAME OF CEMETERY OR CEMETORY

Groce

ADDRESS

Wellman St., J. Bruce Powers

Princess Anne, Md.

24a. REC'D BY REGISTRAR

JAN 19 '61

C. L. Johnson

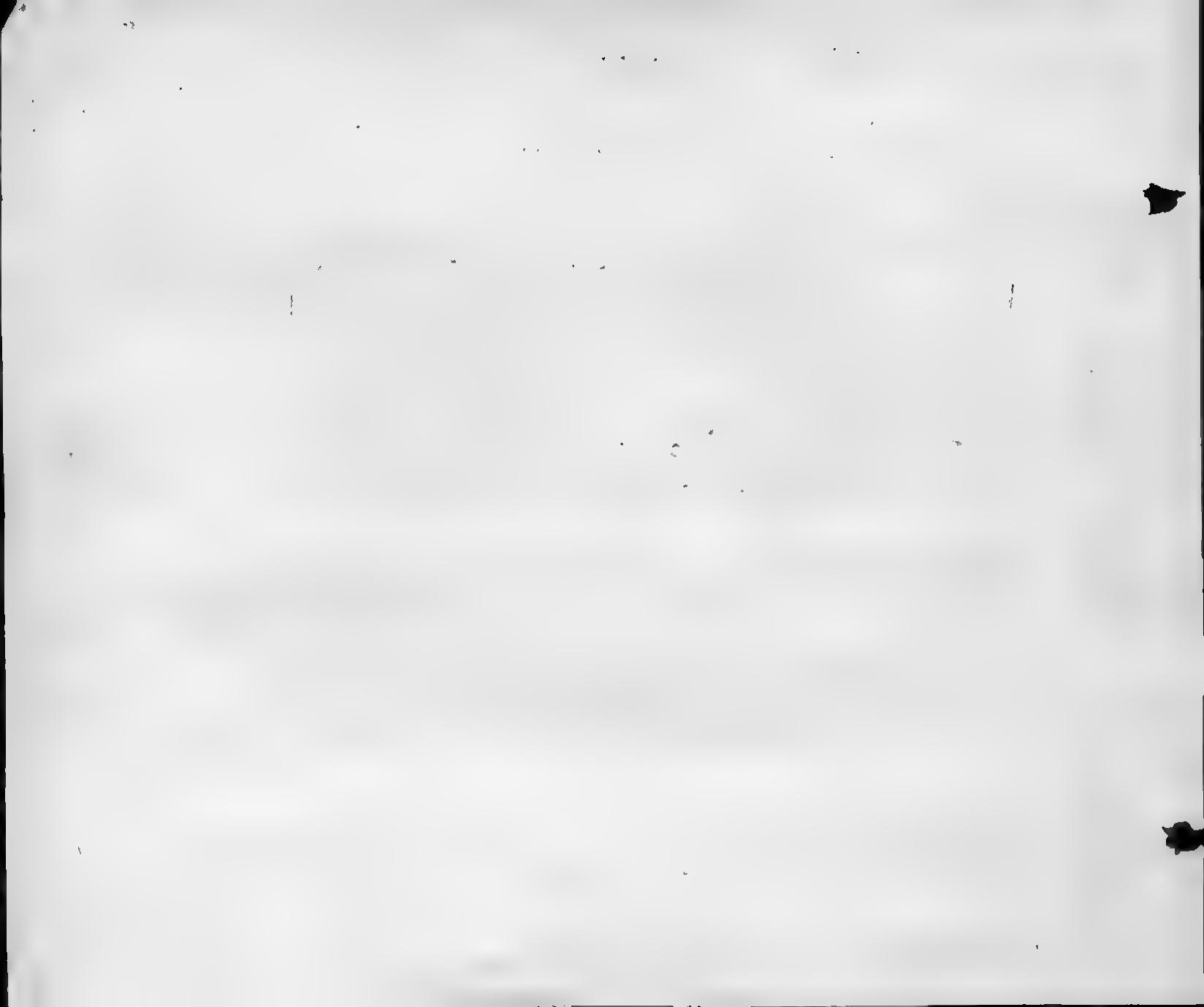
24b. REGISTRAR'S SIGNATURE

C. L. Johnson

DATE JAN 19 '61

W. T. Johnson

Signature



1
THE STATE
HEALTH DEPT.



1
MD MEDICAL EXAMINER This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1139 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1139

1. PLACE OF DEATH a. COUNTY Somerset	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Somerset				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pocomoke - Rural Route #1	c. LENGTH OF STAY IN 1B	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke - Rural Route #1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF (Type or print)	First William	Middle Clifton	Last Spicer	4. DATE OF DEATH January 26, 1961		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/15/1909	9. AGE (in years last birthday) 51 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Factory	11. BIRTHPLACE (State or foreign country) North Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Spicer	14. MOTHER'S MAIDEN NAME Elizabeth ?	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service) No	16. SOCIAL SECURITY NO. 221-10-4899	17. INFORMANT Georgie Hearne - 508 Young Street - Pocomoke, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH 1 year						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour o.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>R. H. Johnson</u> EXAMINER'S NAME (Type) R. H. Johnson, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 29, 1961	22c. NAME OF CEMETERY OR CREMATORIAL Wardtown Cemetery	22d. LOCATION (City, town, or county) (Wardtown)-Pocomoke, Maryland	DATE SIGNED 1/26/61		
23a. FUNERAL DIRECTOR Edgar G. Hartman	ADDRESS New Church, Virginia	24a. REC'D BY REGISTRAR DATE 1/28/61	24b. REGISTRAR'S SIGNATURE Arthur S. Knapp			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1140

CERTIFICATE OF DEATH

Reg. Dist. No. 61168

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. COUNTY	
<i>SOMERSET</i> MARYLAND		<i>MARYLAND</i> <i>SOMERSET</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>WENONA</i>	<i>LIFETIME</i>	<i>X WENONA</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>AT HOME</i>		<i>MAIN ROAD</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>HILDA</i>	Middle <i>THOMAS</i>	4. DATE OF DEATH Month <i>JAN</i> Day <i>18</i> Year <i>1961</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAR 6 - 1896</i>
<i>FEMALE</i>	<i>WHITE</i>		9. AGE (In years last birthday) <i>64 yr.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>HOUSEHOLD</i>	<i>HOUSEHOLD</i>	<i>MARYLAND</i>	<i>U.S.A.</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>WASHINGTON</i>	<i>WEBSTER</i>	<i>ALVERTA</i>	<i>SHORGES</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
<i>No</i>	<i>UNKNOWN</i>	<i>MYRTLE WATERS</i>	<i>ORIOLE MD</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arterionephrosclerosis</i> years (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>diabetes</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19			
21. I certify that I attended the deceased from <i>9-29-58</i> , 19_____, to <i>1-18-61</i> , 19_____, that I last saw the deceased alive on <i>1-18-61</i> , 19_____, and that death occurred at <i>5am</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Everett Sutter</i>	ADDRESS (Street, city or town, state) <i>Dames Quarter, Maryland</i> DATE SIGNED <i>1/19/61</i>		
PHYSICIAN'S NAME (Type)	M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>JAN-20-1961</i>	22c. NAME OF CEMETERY <i>ST. PAUL'S CEMETERY</i>	22d. LOCATION (City, town, or county) <i>WENONA</i> (State) <i>MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>E.G. Webster</i>		ADDRESS <i>Business Annex</i>	24a. REC'D BY REGISTRAR DATE <i>JAN 20 1961</i>
			24b. REGISTRAR'S SIGNATURE <i>John A. French</i>

BY LUMONIALS - HAVING TO TURN SANE BEFORE GOING ON

CONFIDENTIAL TO DIAH

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TO HOSPITAL may be received by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1141

CERTIFICATE OF DEATH

61128

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN TB 66 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peyton Road		d. STREET ADDRESS Peyton Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First DORA	Middle GABLE	Last THORNTON	4. DATE OF DEATH	Month January	Day 6,	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1882	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Gable			14. MOTHER'S MAIDEN NAME Margaret Adams			Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	17. INFORMANT Wm. F. Thornton, 2901 Dunmore Rd., Balto.22, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Type Myocarditis							
422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Cystitis. Severe Leukic Degeneration							
DUE TO (c) Generalized Osteoarthritis							
INTERVAL BETWEEN ONSET AND DEATH 5 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Generalized Osteoarthritis							
1/6 months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/4 to 1/16 , 1961, that (I) (we) last saw the deceased alive on 12/31 1961, and that death occurred at 4 A.M. from the causes and on the date stated above.							
22a. SIGNATURE A. N. Barr				22b. DATE SIGNED 1/16/61			
22c. PHYSICIAN'S NAME (Type) A. N. Barr, M. D.				22d. ADDRESS Main St., Crisfield, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 8, 1961		23c. NAME OF CEMETERY OR CREMATORIAL Asbury ME Cemetery		23d. LOCATION (City, town, or county) (State) Crisfield, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland				ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 13 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Tissue

